AARP

601 E Street, NW
Washington, DC 20049

202-434-2277
1-888-OUR-AARP
1-888-687-2277
TTY 1-877-434-7598
www.aarp.org

STATEMENT FOR THE RECORD

SUBMITTED TO THE

DEMOCRATIC STEERING AND POLICY COMMITTEE
ON

THE URGENT NEED FOR HEALTH CARE REFORM

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AARP
601 E Street, NW
WASHINGTON, DC 20049

WITNESS: Bonnie Cramer
AARP Board Chair

For further information, contact:
Nora Super
Government Relations & Advocacy
(202) 434-3770

Madame Speaker and other distinguished members of this panel, my name is Bonnie Cramer and I am the chair of the Board of Directors of AARP. I want to thank you for your leadership to enact comprehensive health reform legislation to ensure that all Americans have quality, affordable coverage options. This is AARP's top priority this year.

Today, I am proud to represent nearly 40 million members of AARP – half of whom are over age 65 and participate in the Medicare program, and half of whom are under age 65. Both age groups face serious problems in today's health care system, including the fact that over 7 million of all persons age 50-64 are uninsured today. Thank you for inviting me here today to discuss their hopes and concerns.

AARP greatly values the views and opinions of our members and we spend a good deal of time talking with them, meeting with them, and soliciting their input. AARP has engaged tens of thousands of our members all across the country on the subject of health care reform, listening to their concerns, ideas, and solutions. Just since August 1, we have held over 60 tele-town halls, 60 community events, and 30 traditional town hall meetings on the subject of health care reform.

Many of our members also share their personal stories with us. Like Joan D. from Raleigh, North Carolina, who is currently taking 17 different medications, several of which are expensive brand-name drugs for which generics are not available. One pill alone is $500 per month. Joan tells us she's in the dreaded Medicare Part D "doughnut hole" and she doesn't understand how she's supposed to come up with almost $4,000 when her monthly income is only $1,700 and she still has to pay for things like food and utilities.

AARP member Charles A. from Greenville, South Carolina, is 59 years old and had the misfortune of being diagnosed with Multiple Sclerosis (MS) at age 51. Charles told us how he believed in the American healthcare system. He maintained health insurance while raising a family of four and he never took unfair advantage and never let his insurance lapse. After his diagnosis for MS, he battled his insurance company for two years before they finally dropped him. Now he is in "no man's land," too young for Medicare, not employable because of his disability, turned down by Social Security disability, and uninsurable in the private sector. Unfortunately, there is no state high risk pool that offers him an affordable insurance option. Charles is living on a fixed income from his savings, with medical costs of more than $30,000 a year. All of his options are bad.

AARP Member John C. from Grand Prairie, Texas tells us about the waste and fraud he sees in the Medicare program. After an ambulance ride last spring, the home health agency that provided him post-acute care was paid more than twice what they charged Medicare for the services, and it clearly showed that on the bill he received from Medicare. Then, Medicare turned around and denied coverage for the initial ambulance ride, but covered a subsequent ambulance ride when John had to be transferred to another hospital during the same episode of care. John diligently followed up with the ambulance company and the home health agency, and just filed an appeal on the ambulance coverage with Medicare, but he is still waiting for a response. We hope things turn out right for John for all of his efforts but we wonder just how many citizens don't have the time to watch out for these issues of wasteful, overbilling as closely as he does. We believe this is one area where we could save much more.

When we listen to our members about their health care, we hear confusion, frustration, anger, and desperation. Some have fear about the legislation being considered by Congress and many others hope it will help solve their problems with the health care system. Ultimately, AARP believes health care is not a Democratic or a Republican issue. And it's not about political gamesmanship. It's about people's lives. That's why we believe health care reform must fix what's wrong and preserve what's right.

Myths vs. Facts

Because we believe health care reform is so vitally important to so many of our members, AARP has been working hard to help our members cut through the noise and find the facts about what health care reform means for them and their families. Unfortunately, some special interest groups have been using scare tactics such as the notion that health care reform would ration care, hurt Medicare, or result in a government takeover of health care. These statements are just a few of the many falsehoods being spread as a way to block the enactment of true health care reform. I would like to discuss a few of those myths to set the record straight. AARP's *Bulletin* – a monthly publication sent to every AARP household -- this month features a more in-depth article to help clear up much of this misinformation and I have brought extra copies with me today (the *AARP Bulletin* can also be accessed on our website at www.aarp.org).[1]

One common myth is that health care reform is socialized medicine. But the fact is all of the proposals actively being considered by Congress will preserve the employer-based health care system, meaning an estimated 175 million Americans will continue to get their coverage through their employers. Every proposal that Congress is considering would allow people to choose their own doctors and hospitals, and choose between a range of private plans. *AARP believes health care reform isn't about a government takeover. It's about guaranteeing all Americans a choice of health care plans they can afford.*

Another myth is that health care reform means your care will be rationed. The fact is that none of the health reform proposals being considered by Congress would allow the government to make decisions about which care you can receive or get between you and your doctor in deciding which treatment option is best for you. In fact, all of the proposals would require plans to offer benefit packages with a comprehensive range of medical services similar to what's offered in typical employer-sponsored plans. Annual or lifetime limits on coverage would be prohibited and none of the bills place any age limits on receiving medical care. If they did, AARP would certainly be opposed to them.

Another common myth is that health care reform will destroy Medicare to pay for health care reform. Medicare is extremely important to AARP's members so we take this charge very seriously. The fact is that none of the health care reform proposals currently being considered by Congress would cut Medicare benefits or increase your out-of-pocket costs for traditional Medicare services. In fact, every major health care reform bill will lower prescription drug costs for people in the Medicare Part D coverage gap or "doughnut hole" so they can better afford the drugs they need. In addition, health care reform will protect seniors' access to their doctors and reduce the cost of preventive services so patients stay healthier.

[1] Patricia Barry, "Health Care Reform: The Assault on Truth," *AARP Bulletin Today*, August 14, 2009.

Health care reform will help reduce costly, preventable hospital readmissions, saving patients and Medicare money, reduce excessive profits to insurance companies, drug companies and other Medicare providers, and prevent excessive and duplicative testing.

The fact is, rather than weaken Medicare, health care reform can strengthen the financial status of the Medicare program. *It is true that all of the proposals seek to save billions from Medicare costs – not by cutting benefits, but by reducing waste and fraud; reducing preventable hospitable readmissions; reducing unwarranted insurance company subsidies; and setting up new ways to pay doctors more fairly and reward providers for quality of care instead of (as now) paying them a fee for each separate service.*

What AARP is Fighting For

AARP commends your leadership in working through the difficult process of reconciling the different provisions of H.R. 3200 before it goes to the House floor. AARP remains committed to enactment of legislation to hold down costs, expand coverage, and improve our health care delivery system, without adding to the deficit.

While AARP has not endorsed any comprehensive reform legislation to date, we will support measures that bring down health care costs and that achieve the following for our members:

- **Ending Discrimination By Insurance Companies** by preventing insurance companies from denying health insurance because of a pre-existing condition or using age to price Americans age 50-64 out of affordable, quality health insurance.

- **Strengthening and Improving Medicare** by ensuring seniors get the benefits they've earned, closing the Medicare Part D "doughnut hole," maintaining patients' access to their doctors, and strengthening the Medicare Trust Fund by eliminating fraud and wasteful spending.

- **Protecting Consumers and Choices** by making sure no one will get between you and your doctor – not insurance companies or the government -- and that no one tells you which doctors or treatments you should have; and ensuring that people's health doesn't take a back seat to insurance or drug company profits.

- **Guaranteeing Stable, Affordable Coverage** by ensuring that all Americans have the security of knowing that if they lose their job or change jobs, they will be able to get affordable, quality health insurance.

To this end, as you put together the final bill for a vote on the House floor, I would like to highlight the provisions of highest priority for AARP, which we believe will have the most significant impact on AARP's nearly 40 million members, half of whom are over age 65 and therefore participate in the Medicare program, and half of whom are under age 65.

Affordability

There are few issues of greater concern to AARP's membership than assuring that all Americans have available to them affordable high quality coverage choices. Many older Americans, especially those aged 50-64 who are not yet eligible for Medicare or those with pre-existing chronic conditions, often cannot secure health coverage, at any price. Industry data show that insurers reject between 17 percent and 28 percent of applicants aged 50-64.[2] Those who can find individual coverage tend to receive less generous benefits than those with employer coverage, yet on average pay three times more in premiums and over twice the out-of-pocket spending of those with employer coverage.[3] The AARP Public Policy Institute estimates that 13 percent (or 7.1 million) adults aged 50-64 were uninsured in 2007 – 1.9 million more than in 2000 – and this figure is growing rapidly in our current difficult economy.

Age Rating--AARP strongly supports the House provisions to limit age rating to no more than a 2-to-1 ratio. We have serious concerns about the adverse impact on AARP members and cannot support other proposals under consideration that would allow insurers to charge older Americans five or more times higher premiums than others simply because they are older. Age discrimination is just as inappropriate as discrimination by gender and medical history. It is a fact of life that sooner or later all of us will eventually become older, but it shouldn't be a fact that as we age, discriminatory practices are allowed to exist that make it difficult for us to gain access to affordable insurance. AARP believes that if age rating is not seriously constrained, it could simply become another way for insurers to underwrite their policies and select only the healthiest and youngest individuals – leaving our members to face rates that many will not be able to afford.

AARP's preference would be to eliminate age rating altogether, but if it is to be allowed, age rating bands should be extremely narrow – reaching no more than a 2-to-1 ratio. Some have suggested that a 5-to-1ratio would be enough to improve the situation many older Americans face today in states that have no age rating limits – however, such age rating may still leave coverage unaffordable for millions of older Americans.

In Massachusetts, which recently enacted comprehensive health care reform, the state has capped age rating at 2-to-1. Yet affordability is still a significant issue for many AARP members. At that 2-to-1 age rating the lowest cost "bronze" benefit package costs 60-year-olds between $420 and $575 per month. If the rate band were set at 5-to-1, the bronze package monthly costs would jump dramatically to between $1,050 and $1,335, or up to $16,020 a year -- over half the median annual income of $30,000 among uninsured Americans aged 50-64 today.[4]

And contrary to some assertions, older uninsured Americans do not have substantially higher incomes than younger uninsured individuals, whose median income is $28,461, only slightly lower than uninsured 50-64 year olds.[5] Continuing to allow health care coverage to remain

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[2] AHIP, "Individual Health Insurance 2000-2007: A Comprehensive Survey of Premiums, Availability, and Benefits." December 2007.

[3] AARP Public Policy Institute, Health Care Reform: What's at Stake for 50- to 64-Year-Olds?, March 2009.

[4] AARP Public Policy Institute analysis of U.S. Census March 2008 Current Population Survey.

[5] Ibid.

unaffordable is a problem not just for individuals who need it most, but for taxpayers and others with insurance. Uninsured individuals are most likely to forego necessary preventive care and rely on emergency room services for their treatment which increases health care costs for all as their uncompensated health care costs are shifted to those who have insurance. In addition, uninsured adults in their late 50s and early 60s experience worse health outcomes and use more services when they enter the Medicare program, driving up the costs to the federal government.

Subsidies- AARP strongly supports the House bill language that would provide subsidies to individuals up to 400 percent of the federal poverty level. Without these subsidies, many of our members will not be able to afford coverage or the cost sharing for covered care. In addition, AARP believes the highest income group should continue to get protection on premiums up to 11 percent of income, at a minimum, as was provided for in the original bill. We believe that efforts to increase these percentage limits or decrease the subsidy levels will erode the affordability protection of the credits, and will mean that over time more people will find insurance unaffordable. Protections on out-of-pocket spending through the actuarial standard, credits, and stoploss, are also very important.

As you know, the bill would require, for the first time, that all individuals be required to purchase insurance. But individuals should not be required to purchase something they cannot afford. Therefore, it is critically important that Congress provide adequate subsidies to assist individuals who need extra help in purchasing insurance. If individuals cannot afford to purchase insurance, they will still have no coverage and this legislation will be of no help to them. Public acceptance will depend upon premiums set at reasonable levels, and we urge no further retreat from the affordability provisions contained in the House bill. As such, reasonable age rating and affordability credits are AARP's top priorities for the half of our membership under the age of 65.

AARP also supports amendments that were accepted that would allow state health care reform initiatives to continue, specifically in Vermont, Massachusetts, and Hawaii. In addition, we support the amendment accepted in the Energy and Commerce Committee that provides higher Medicaid match rates in the U.S. Territories.

Medicare Savings and Reinvestments

An important part of health care reform is protecting Medicare and getting better value for both Medicare beneficiaries and the federal government. Millions of our members rely on the Medicare program and we have pledged to them that we will not support any health care reform proposal that does not strengthen and improve Medicare so seniors continue to get the benefits they've earned and their children and grandchildren have the health coverage they need when they retire. AARP believes, as President Obama stated last Wednesday in his address to the Joint Congress, that our government's commitment to older Americans through Medicare is a "sacred trust" that must not be broken.

That is why we have made it clear to Congress and the President that any final health care reform plan must use savings obtained by reducing waste, fraud, and inefficiency from Medicare to close the Part D "doughnut hole"; pay doctors more fairly so our members will continue to have access to the doctors they need; improve care by covering more preventive

services such as cancer screenings; and keep premiums fair and hold down out-of-pocket costs.

We all agree that reducing the growth of health care spending must be a national priority. The Congressional Budget Office and others have pointed out that there are serious concerns regarding the efficiency of the health care system. Vital health programs are threatened by the needless waste of health care resources. And, in addition to wasting money, people's health is also put in jeopardy when they receive services that are not beneficial.

Transitional Care Services--One critical area where Medicare can reduce waste, improve quality, and achieve savings is by reducing preventable or unnecessary hospital readmissions. One-fifth of Medicare beneficiaries were re-hospitalized within 30 days of discharge and one-third were readmitted within 90 days according to a *New England Journal of Medicine* study published earlier this year. The study also estimated that Medicare spent over $17 billion on largely preventable re-hospitalizations in 2004. This is wasted money for Medicare and means that too many Medicare beneficiaries were subjected to unnecessary hospitalizations. It is a serious problem that demands robust solutions.

A recent AARP study of older adults with chronic conditions found that nearly one in five (18 percent) said that their transitional care was not well coordinated. Patients discharged without transitional care services frequently report difficulty remembering clinical instructions, confusion over correct use of medications, and uncertainty over their prognosis. Without assistance, most family caregivers lack the knowledge, skills and resources to effectively address the complex needs of older adults coping with multiple conditions.

Both changes in payment policy and the effective provision of transitional care services for high-risk Medicare beneficiaries have an important role to play in reducing unnecessary hospital readmissions. We are pleased that H.R. 3200 includes changes in payment policy to help reduce preventable hospitalizations and that the concept of transitional care services is also included in the bill. It is critical that Medicare beneficiaries receive effective transitional care services to help both patients and their family caregivers prior to and after hospital discharge by keeping them healthy and out of the hospital in the future.

However, AARP believes that the transitional care provisions of H.R. 3200 should be further strengthened to better target high-risk Medicare beneficiaries; provide transitional care services based on evidence-based models; help ensure that multiple appropriate entities, clinicians, and individuals can provide transitional care services; and ensure appropriate evaluation of transitional care services. These are elements contained in the Medicare Transitional Care Act (H.R. 2773) that AARP has strongly endorsed. We believe that providing effective transitional care services to the Medicare beneficiaries who need them the most will get these patients and their primary caregivers the support they need, improve quality, reduce preventable hospital re-admissions, and save Medicare money.

Health Information Technology--We have also endorsed other approaches to improve health care quality—which, in turn, will improve efficiency and eliminate unnecessary spending. The broader use of health information technology (HIT) — not just more widespread adoption — but *effective* use of the technology to actually improve health outcomes is another example. AARP believes that using HIT to manage, process, and exchange health information is an essential clinical competency that will yield better patient outcomes and promote more

efficient use of resources. Yet we also know that not all clinicians now have the skills to maximize the value of HIT. Congress wisely included funding for technical assistance through the HIT Extension Centers in the American Recovery and Reinvestment Act of 2009 ("ARRA") to help clinical practices acquire the necessary proficiency to use HIT to realize its potential for improved care and cost reductions (e.g., avoidance of duplicative tests, decision support based on evidence-based guidelines).

Another area of potential savings would emerge if clinicians were able to base their decisions on firm scientific knowledge of what works and what doesn't and for which patients. In the current system, clinicians simply do not have adequate information to be certain that the interventions and treatments they provide are appropriate. HIT and enlarging the clinical knowledge base will eventually yield savings, and AARP commends Congress for having included funding for comparative effectiveness research in the ARRA to advance these goals. Knowledge about what works best in medical care is extremely valuable, but should always be applied with sensitivity to the individual diagnoses and medical needs of the patient.

Medicare Advantage—AARP also supports congressional efforts to reduce excess subsidies to private insurance companies that participate in the Medicare program. We have examined the evidence presented by the Congressional Budget Office and the independent Medicare Payment Advisory Commission (MedPAC) and believe it is inefficient and wasteful to use taxpayer dollars to subsidize private insurance companies. These subsidies boost insurer profits but do little to help the majority of beneficiaries. Indeed, these excessive subsidies significantly increase premiums for all Medicare beneficiaries. That is why we support the provisions contained in all of the major health care reform proposals being considered in Congress to reduce these excessive payments. We believe that by reducing these subsidies, we can save money, lower Medicare costs, and help ensure older Americans – both now and in the future -- will have the health coverage they need when they retire.

However, we know that many Medicare beneficiaries rely upon Medicare Advantage plans to receive their care and we believe that those plans that deliver high quality care should continue to be available in the Medicare program. Therefore, AARP urges Congress to retain provisions providing quality bonuses to those plans that provide high quality care. We believe this is consistent with efforts by the Centers for Medicare and Medicaid Services to reward other Medicare providers (e.g., hospitals, physicians, nursing homes) and is a sound basis for future Medicare payment system reforms. Indeed, the use of bonus payments for quality performance has been endorsed by the Institute of Medicine and MedPAC as a powerful tool to improve the performance of our health care system and reduce variations in quality. We believe such improvements will strengthen the quality of care delivered to Medicare beneficiaries and, ultimately, better align payment policy with the health outcomes we want to achieve. Moreover, rewarding quality will reduce wasteful expenditures of health care dollars.

There are other steps that could be taken to motivate behavioral changes to accelerate improvement and to achieve cost reductions. Several of these ideas are reflected in the reform proposals now being discussed. For example, greater support for patient preferences and informed, shared decision-making could yield savings. There is compelling evidence that when consumers receive information about their treatment options, they make more conservative—often less expensive—choices. There are several high value preventive services that have been demonstrated to save money by warding off costly complications. Adherence to such preventive measures would be advanced by targeted reductions or

elimination of patient cost sharing as proposed in the House legislation.

AARP does not support Medicare policies that would result in arbitrary across-the-board cuts to payments, reduced benefits, or increases to the already considerable burden on beneficiaries to spend money out of their own pockets. We appreciate that H.R. 3200 does not contain those types of policies. The vast majority of the savings proposals put forward by Congress have a sound policy basis and are supported by non-partisan advisory organizations such as the Medicare Payment Advisory Commission (MedPAC), the Institute on Medicine, and the National Quality Forum.

Nonetheless, because the savings being considered from the Medicare program are quite significant, AARP suggests that MedPAC be required to give special attention to the impact on beneficiaries' access and quality of care as this law is implemented. If MedPAC deems that additional resources are necessary to fully analyze the impact on beneficiaries, we urge Congress to appropriate these funds. In addition, if MedPAC determines that beneficiaries' access or quality of care is likely to be adversely impacted because of these payment changes, we urge the Commission to recommend steps to prevent these impacts, and for Congress to enact them as soon as possible. Cost savings alone should never be the ultimate goal of policymakers – rather, assuring access to quality care and meeting the needs of Medicare beneficiaries should be paramount.

Policies to Reduce Prescription Drug Costs

AARP strongly supports improvements to Medicare Part D in the House legislation that would gradually close the doughnut hole in Medicare Part D as well as, beginning in 2011, provide discounts on brand-name drugs to beneficiaries who fall within the doughnut hole. While discounts are important in order to provide immediate relief, closing the coverage gap over time is critical to ensuring that our members with high drug costs can afford their medications. Absent such action, this coverage gap will double over the next decade. We are pleased that the Administration, in addition to its earlier support for discounts, recently announced its support for closing the doughnut hole completely over time. In addition, we strongly support an amendment adopted during the House Energy and Commerce markup that would allow the Secretary of Health and Human Services to negotiate directly with drug manufacturers for lower prices on prescription drugs on behalf of Medicare beneficiaries.

AARP strongly opposes an amendment adopted by the House Energy and Commerce Committee that would grant manufacturers of biologics drugs 12 years of market exclusivity before generic equivalents can be made available to consumers. The use of these lifesaving drugs is becoming more prevalent, and yet the costs of these drugs have become too high for too many of our members. The independent Federal Trade Commission recently concluded that biologic manufacturers could achieve a return on their investment within 5 years. We are disappointed that this amendment to delay access to lifesaving drugs has been adopted and urge that it not be incorporated into the final bill.

Long-Term Care

Another key priority in health care reform for older adults and persons with disabilities is long-term services and supports (LTSS) – specifically the assistance people need to live independently in their homes and communities. Among individuals age 50 and older, 89 percent say they want to live in their homes and communities for as long as long as possible. However, individuals need much better access to home and community-based services (HCBS) and ways to pay for them. Medicaid is the largest payer of LTSS in the country, yet the program contains a bias toward providing services in institutional settings, rather than home and community-based settings, where individuals prefer to receive services and where services can often be provided at lower cost. Research by AARP's Public Policy Institute found that 73 percent of Medicaid long-term care spending for older people and adults with physical disabilities paid for institutional services, with only 27 percent going to HCBS. And HCBS are usually more cost effective – on average, Medicaid dollars spent on HCBS can support nearly three older adults or individuals with disabilities for every person in a nursing home.

AARP strongly supports provisions in H.R. 3200 added during the Energy and Commerce Committee mark up for a voluntary public insurance program for long-term services and supports – the so-called CLASS Act provisions. We also encourage the addition of CLASS Act provisions in the Ways and Means Committee's jurisdiction to enable the implementation of this important public insurance program. The CLASS Act provisions will give eligible individuals another way to help them pay for their long-term care needs, and to have choice and control over the services and supports they need to help them live independently in their homes and communities.

AARP urges that H.R. 3200 be further strengthened as it moves forward to improve access to HCBS under Medicaid. Individuals who rely on Medicaid should have greater access to services that help them live in their homes and are cost-effective. We support the inclusion of provisions to expand access to HCBS and give states financial incentives to provide these critical services, such as the provisions in the Empowered at Home Act (H.R 2688).

Conclusion

I **would** like to close by dispelling one more popular myth: **health care reform is too expensive and we can't afford to fix** it. In fact, if we do nothing to fix health care, families with Medicare or employer-based health coverage will likely see a repeat of history – their premiums will nearly double again over the next seven years. Moreover, if we do nothing to fix health care, the share of family income spent on health care will nearly double over the next seven years. In addition, the rising costs of health care will continue to increase the burden on employers, as well as state and federal government program costs.

When one in three Americans say someone in their family skipped pills, postponed or cut back on needed medical care due to the cost; when countless bankruptcies are related to medical expenses; when the number of uninsured approaches 50 million; when government spending on health programs rises so rapidly that it jeopardizes other priorities; and when employers struggle to pay for the costs of health care, the fact is, we can't afford not to fix health care.

Thank you again for your continuing leadership to improve our nation's health care system. We look forward to working with you to enact a comprehensive health care reform package that holds down health care costs, protects and improves Medicare, and improves coverage for all older Americans. I appreciate the opportunity to be with you today and I look forward to answering any questions you may have.